STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145485	A. BUILDING _____ B. WING _____	C 3/24/04

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA WOOD HEALTH CARE CTR	900 NORTH MARKET STREET WATSEKA, IL 60970

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F9999	FINAL OBSERVATIONS 300.610(a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility. 300.1210(a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and	F9999		

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F9999	Continued From page 25 psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the residents. 300.3240(a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 300.3240(b) A facility administrator, employee or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. 300.3240(c) Employee as perpetrator of abuse. When an investigation of a report of a suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigated, prosecution or disciplinary action against the employee. Based on record review, interview, and observation, the facility failed to protect one of two sampled residents (R9) from physical and mental abuse by failing to intervene for R9, allowing an employee to abuse R9 on four separate occasions (forcing R9 to get out of bed, forcing him to take a shower, grabbing and bruising his wrist, spraying water into his face with the shower hose). The facility failed to ensure the security of the building (loose exit door closure and hinge) allowing an off duty employee access to all residents and subsequent	F9999		

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abuse to R9. The facility failed to properly train the charge nurse on the facility 's Abuse Prevention and Prohibition program prior to assigning her to the midnight shift. Facility staff failed to have a good working knowledge/competency of the abuse policy and failed to immediately report resident abuse to the Director of Nurses (DON) or Administrator resulting in further incidents of physical/mental abuse to R9.

Findings are:

1. According to R9's medical record, he is 87 years old with diagnoses which include Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Cerebral Vascular Accident. R9's Resident Assessment Instrument dated 01-25-04, shows that he is cognitively impaired and has problems with short and long term memory. He is dependent on staff for his care including his bathing. He is unable to ambulate or to transfer himself. R9's careplan dated 02-01-04 shows that he requires 2 assist to transfer, refuses to get out of bed, does not like to leave his room, is confused, and he resists care. The facility's Resident Risk Assessment: Abuse and/or Neglect dated 01-26-04, indicates that R9 is at risk for Abuse/Neglect.

The facility's abuse investigation report regarding an incident on 02-24-04, states that E10, Certified Nurse Aide (CNA), entered the facility some time between 11:30p.m. on 02-23-04 and 12:10a.m. on 02-24-04 to give R9 a bath. It was reported to E17 (Administrator at the time), that the employee's behavior was questionable for intoxication or substance abuse. Review of E10's timecard

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shows that E10 worked 11:53a.m. to 8:15p.m. on 02-23-04. That was also, her last day worked. On 03-10-04, at 3:00p.m., E1 confirmed that E10 was not on duty during the time of the incident.

E5, Licensed Practical Nurse was interviewed on 03-10-04 at 8:52a.m. E5 stated she was in charge of the 10:00p.m.-6:00a.m. shift, between 02-23-04 and 02-24-04. She stated, "(E10) was trying to get (R9) up. I asked her to leave him alone. She refused. I walked away, out of the room. I came back and he was up. By her actions I knew she wasn't ok. She was here late, before midnight. She was unsteady on her feet. I didn't know who she was. I hadn't worked with her. I kept an eye on her. E10 was very determined to get him up. He didn't want to get up I said leave him alone and she acted like she didn't hear me. I wondered even before she got him up if she had been drinking by the way she walked, unsteady. After he was put back to bed, he showed me his right wrist. It was bruising."

On 03-10-04 at 2:00p.m., with E1, Administrator, and Corporate representative present, E5 was interviewed again. E5 stated, "I didn't know (E10) was here until (E8 and E9, CNAs) told me. I went down to his room around 9:30p.m.-10:00p.m. (E5's time card shows that she arrived to work at 9:54p.m. on 02-23-04). I observed (E10) to see why she was there. (R9) did not want to get up. (E10) kept on trying to get him up. I told her, 'I think we should leave him alone.' She acted like she didn't hear any of us. She insisted on giving him a bath. Since (E10) was not responding, I called the Director of Nurses. She told me that (E10) should not be there since she was not scheduled to be on duty. I then went

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to the shower room. At that point (E10) was finishing with (R9's) bath. When he was put back to bed, he said (E10) had grabbed his wrist. At that time, (E10) was in the hallway. She was suspicious. (E10) was not receptive to the idea of leaving. I had asked her to leave him alone. She left 10 minutes later. E8, (CNA) had told me about her (E10) drinking after R9 was in the shower and while he was in the shower, I called the Director of Nurses again and was told to call the police. I went to the shower room. R9 complained of his wrist in the shower room. E10 was in the activity room."

Observation of R9 on 03-09-04 at 11:47a.m., showed that R9's right wrist had a large reddish purple ecchymosis encircling his wrist. When surveyor asked R9 what had happened? R9 stated, "She grabbed my wrist. She wanted to take me for a bath.....I didn't want a bath. I don't know her. She was about half drunk. I could smell it."

At approximately 3:00p.m., on 03-10-04, E5 stated that she had read the Abuse policy upon hire 02-04-04 but had not attended an inservice prior to her assignment as charge nurse on the 10:00p.m.-6:00a.m. shift.

E1, current Administrator, was interviewed on 03-09-04 at 11:35a.m. and on 03-12-04 at 1:37p.m. E1 stated she was employed as the facility's Director of Nurses on 02-24-04. E1 stated, "I received a call on 02-24-04 at 12:15a.m. regarding E10. E5 told me that E10 was in the building after hours to give R9 a shower. I told E5 to tell E10 to leave the building and not to return until called but, E10 had already left. I immediately reported this to E17, the Administrator, at the time. E5 did not report to me the wrist injury or that E10 had

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sprayed R9 in the face. I didn't find that out until the next day. E10 was suspended on 02-24-04 and fired on 03-02-04. E17 reported the incident to Illinois Department of Public Health on 02-25-04."

E8, CNA was interviewed on 03-09-04 at 12:17p.m.; 03-10-04 at 3:17p.m.; and 03-11-04 at 3:56p.m. E8 stated, "E10 was repeating herself a lot. She was speaking loudly but wasn't yelling. I smelled alcohol strongly on her breath in the shower room and R9's room. I immediately told E5 and she called E1 (Director of Nurses), at that time. When I entered the shower room after reporting to E5, E10 was squirting R9 right in the face with the shower hose. She told me she was trying to get the shaving cream off him. I told E5 after I saw that. She was still in the hallway. I then went back into the shower room. I did not say or do anything to E10, I was waiting for the nurse to do that. I saw E10 come in the activity room door between 11:30p.m. 02-23-04 and midnight 02-24-04. It is supposed to be locked but, it's kind of quirky (doesn't always close right)." E8's written statement regarding this incident states that E10 went into R9's room and tried to convince him to take a shower. He was pushing and hitting her and E10 continued to insist. Finally she got him upright and put him in the shower chair. E10 fell on the floor. We undressed him, he flung his arm back and threw E10 against the wall.

During interview with E9, CNA on 03-10-04, at 9:31 a.m., she stated, "E10 came in between 11:30p.m. (02-23-04) and 12 midnight (02-24-04). E10 told E8 that she was going to give R9 a shower. I saw E8 and E10 transfer him onto a shower chair. E10 lost her balance and fell. R9

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was fighting. He didn't want to take a shower. E8 told E5 that she thought E10 was drinking before she told one of us to go into the shower room. While E10 was taking R9 to the shower room, we stayed to make his bed. Ten minutes later, we heard R9 yell in the shower room. That's when E5 said one of us needed to go in there with E10. I refused. I didn't want to get involved with that. E8 and I took him back to his room. Shortly after that, 10-15 minutes later E10 left the building. E10 was acting high strung and silly. She was acting like she was high and talking loud. But she wasn't cussing."

E9's written statement, as part of the facility's investigation, states that E10 came into the building around 11:30p.m. and stated that she wanted to give R9 a bath. E10 went into his room, he wasn't very cooperative, after a short time of talking to him, E8 assisted E10 to transfer R9 into the shower chair. E10 took him to the shower room. E8 told E5 that E10 had been drinking that night. E9's statement includes the fact that when E8 saw E10 spraying R9 in the face that E8 asked E10, 'what are you doing?'

There is no evidence that E8 or E9 attempted to intervene when E5, LPN failed to act after being notified of E10's behavior towards R9.

2. Interview with E16, Maintenance man, on 03-11-04 at 3:11p.m., verified E8's statement that the activity exit door doesn't always close right. E16 stated, on 03-11-04 at 3:11p.m., "The (exit door off the activity room) door closure wasn't working right. The closure came loose about 2-3 weeks ago. It would have prevented the door from closing. It was fixed right away. The date of the

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repair is in the record book with the date we fixed it." Review of the maintenance record confirmed that repair of the activity door hinge and door closure was done 02-24-04. The facility's repair requisition dated 02-24-04, shows repair needed to check entry/exit door-assure proper closure and locking is correct. Location-Garden room/activity room.

3. Review of February staffing schedule and E5's time card shows that E5 was on duty 02-24-04 and was the nurse in charge. She was the only nurse on duty. During interview with E5 on 03-10-04, at 2:47p.m., she stated, "I've worked here one and one half months. I have had no abuse inservice. I read the policy when hired." Review of E5's personnel file shows that E5 was hired 02-04-04 as a Licensed Practical Nurse. The UNDERSTANDING AND RECEIPT OF RESIDENT ABUSE AND NEGLECT DETECTION AND PREVENTION POLICY dated 02-03-04 bears E5's signature signifying that E5 reviewed, understood, and received a copy of the Resident Abuse and Neglect Policy.

E5 stated during an interview on 03-10-04 at approximately 3:00p.m. that she had read the Abuse policy upon hire (02-04-04) but had not attended an inservice prior to her assignment as charge nurse on the 10:00p.m.-6:00a.m. shift. The facility's Abuse, Prevention and Prohibition policy states under section II. TRAINING: Facility staff shall be trained on the abuse prohibition program during orientation and on going during educational sessions.

The facility inservice record dated 12-10-03, shows that an inservice on Abuse and Neglect was